

APPENDIX 9
PRIOR AUTHORIZATION REQUEST FORM (PA/RF) SAMPLE

MAIL TO: E.D.S. FEDERAL CORPORATION PRIOR AUTHORIZATION UNIT 6406 BRIDGE ROAD SUITE 88 MADISON, WI 53784-0088				PRIOR AUTHORIZATION REQUEST FORM <div>PA/RF</div> (DO NOT WRITE IN THIS SPACE) ICN # A.T. # P.A. # 1234567				1 PROCESSING TYPE <div>138</div>					
2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER 1234567890				4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE) 609 Willow Anytown, WI 55555									
3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL) Recipient, Im A.				8 BILLING PROVIDER TELEPHONE NUMBER (xxx) xxx-xxxx									
5 DATE OF BIRTH MM/DD/YY				6 SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>									
7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE. Anytown CSP 1 W. Williams Anytown, WI 55555				9 BILLING PROVIDER NO. 87654321									
				10 DX: PRIMARY 295.70 Schizo-affective disorder									
				11 DX: SECONDARY									
				12 START DATE OF SOI: N/A		13 FIRST DATE RX: N/A							
14	PROCEDURE CODE	15	MOD	16	POS	17	TOS	18	DESCRIPTION OF SERVICE	19	QR	20	CHARGES
	W8901				4		1		Clozapine Management		26		X,XXX.XX
22 An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAF reimbursement will be allowed only if the service is not covered by the HMO.											TOTAL CHARGE	21	X,XXX.XX

23	MM/DD/YY DATE	24	C. J. P. Psychiatrist, M.D. REQUESTING PROVIDER SIGNATURE
(DO NOT WRITE IN THIS SPACE)			
AUTHORIZATION:		PROCEDURE(S) AUTHORIZED	
<input type="checkbox"/>	GRANT DATE	<input type="checkbox"/>	QUANTITY AUTHORIZED
APPROVED		EXPIRATION DATE	
<input type="checkbox"/>	MODIFIED	REASON:	
<input type="checkbox"/>	DENIED	REASON:	
<input type="checkbox"/>	RETURN	REASON:	
DATE		CONSULTANT/ANALYST SIGNATURE	